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Financial Policies

Thank you for choosing us for your gynecological care. The following information is to advise you of our Financial Policies that has been established by the physician of this practice and is in effect at the time of your visit.

SELF PAY PATIENTS

All fees for service rendered will be paid **in full** at the time of your visit.

CO-PAYMENTS

Co-payments will be collected at the time of your visit. If you do not have your co-payments at the time of service, then your office visit will have to be rescheduled. We will not bill you for your co-payment. For your convenience, we accept cash, ATM, MasterCard & Visa cards.

After 30 days an **18%** finance charge will be applied to any unpaid balances. In case of default of payment, you will be responsible for attorney, collection, and court fees. We report all delinquent accounts to all credit bureaus.

NO SHOW APPOINTMENT FEE

A **\$50.00** charge will be billed to you for failing to keep your appointment and not providing at least a **24 hour cancellation notice**.

PARTICIPATING INSURANCE

The physician's billing representative(s) will file your office visits and surgeries to your insurance. We will complete all requirements to get your claims paid in a timely fashion. [However, all claims not paid by your insurance after **45** days from the date of filing **WILL** become your responsibility. If your insurance pays the claim after you have paid, then you will be reimbursed all the monies due to you in a timely manner. It is **YOUR** responsibility to ensure that your insurance company upholds their responsibility of prompt payment to the physician. It is also your responsibility to check with your insurance to verify that the physician is a participating provider with your insurance prior to services rendered.

PLEASE NOTE: If you do not have a valid insurance card (enrollment information will not be acceptable), you will be required to pay in full at the time of service. We will then bill your insurance when acceptable information is received.

Please sign receipt and acknowledgement of this FINANCIAL POLICY

Patient Signature

Parent/Legal Guardian if patient is a minor

Print Patient Name

Date: _____